

Exhibit 27-10

SAMPLE REMITTANCE ADVICE – PAID FACILITY OUTPATIENT CLAIMS

REPORT ID: FI04W400
PROGRAM ID: FI04L400

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
FACILITY REMITTANCE ADVICE - ACUTE
PAID CLAIMS - INVOICE DATE: 08/01/2005

PAGE: 4
RUN: 08/03/2005

BILLING PROVIDER: 654321 01 ARIZONA HOSPITAL
SERVICE PROVIDER: 654321 01 ARIZONA HOSPITAL

INVOICE NUMBER: A9800000000001
CHECK NUMBER: 48746
PAYMENT DATE: 08/05/2005

TAX ID: 999999999
FORM TYPE: OUTPATIENT

AHCCCS ID	NAME	CRN	DATES OF	BILLED AMOUNT	ALLOWED	
RECIPIENT	PATIENT ACCOUNT NUMBER	STATUS DATE	SERVICE	BILLED UNITS	UNITS	
A12345678	OAKLEY, ANNIE	050000000000	07/04/2005	136.00	57.26	ALLOWED AMOUNT (*)
A12345678	0011617768-1	07/28/2005	07/04/2005		57.26	NET PAID AMOUNT

PRICE EXPL: CCO - .4210) *AHA

NUMBER OF CLAIMS: 1
TOTAL BILLED AMOUNT: 136.00
TOTAL REMIT AMOUNT: 57.26